Provide Information about all individuals receiving vaccine today (Please Print):

Address: _____ City: _____ Zip Code: _____ Phone Number: _____

Please Do Not Fill Out Grey Areas.

Last Name	First Name	Birth Date	Age	Male or Female	Insurance #1, #2 or #3 (List Below) No insurance mark "NA"	American Indian or Alaskan Native?	Vaccine and Lot Number	Provider Name or Initials	Site	SB Done

1. Insurance Information (Including Medicaid, Medicare and Private):

Insurance Company: _____

Policy/ID #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

2. Insurance Information (Including Medicaid, Medicare and Private):

Insurance Company: _____

Policy/ID #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

3. Insurance Information (Including Medicaid, Medicare and Private):

Insurance Company: _____

Policy/ID #: _____ Group #: _____

Policy Holder Name: _____ Policy Holder DOB: _____

For Medicaid, list the Medicaid number in the Insurance column above for each individual person.

Screening Reviewed and Education Provided by: _____

Eastern Idaho Public Health
Prevent. Promote. Protect.

2020-2021 Influenza Vaccine Screening Form

Injectable Vaccine

	List name of person(s) who answer yes to the question and explain.
1. Have you/your child ever had a serious reaction to a flu vaccine in the past?	
2. Have you/your child ever had a serious allergic reaction after eating eggs?	
3. Do you/your child have an allergy to gentamicin, neomycin, polymyxin or gelatin?	
4. Have you/your child ever had Guillain-Barré Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	

If you are choosing the injectable flu vaccine stop here.

Live Attenuated Intranasal Influenza Vaccine (Spray)

For use with people age 2 through 49 years: The following questions will help us determine if there is any reason we should not give you live attenuated vaccine (LAIV, FluMist) today. If you answer yes to the question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please speak to a nurse.

	List name of person(s) who answer yes to the question and explain.
1. Do you/your child have any allergies to medication, food, or any vaccines?	
2. Do you/your child have a long-time health problem with heart disease, lung disease (including asthma), kidney disease, neurologic disease, metabolic disease (e.g., diabetes), or have a cochlear implant or spinal fluid leak, or no spleen?	
3. Do you/your child have cancer, leukemia, HIV/AIDS, or any other immune system problem; or, in the past 3 months have you taken medication that affects the immune system (e.g., prednisone or other steroids, drugs for the treatment of rheumatoid arthritis, Crohn's disease, psoriasis, or anticancer drugs) or have you had radiation treatments?	
4. Are you/your child taking influenza antiviral medication?	
5. Have you/your child received any other vaccinations in the past 4 weeks?	
6. Are you/your child pregnant or could become pregnant within the next month?	